2015-2016 Insurance Information Form

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

Information about the person to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*	Date of birth: * _____ ____ _____ Month Day Year	Age*	Sex: (Circle)* Male Female
Street Address:*			
City:*	State: *	Zip:*	Phone:* ( )

Insurance Information: *Include the whole member ID number and any letters that are part of that number*

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)
Medicare Number:	Is Medicare Primary? Yes No	Is Subscriber Retired? Yes No

If person getting vaccinated is <u>not</u> the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * _____ ____ _____ Month Day Year	Sex: (Circle)* Male Female
Subscriber's Street Address:* (If different from address above)		
City:*	State:*	Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

I give permission to be vaccinated and for my insurance company to be billed.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

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For Clinic/Office Use Only:

Date of Service	Vax Type	Vaccine Mfgr (Circle)	Lot No	Exp Date	Dose (mL)	State Supplied (Circle)	Preserv Free	Injection Route	Injection Site (Circle)	Date On VIS	Date VIS Given
	IIV3 High Dose	Sanofi			0.5	No	Yes	IM	R Arm L Arm	8/19/15	Same as date given
	IIV4	Sanofi GSK		6/30/16	0.5	Yes No	No	IM	R Arm L Arm	8/19/15	Same as date given
	LAIV4	Med-Immune			0.2	Yes	Yes	Intranasal	NA	8/19/15	Same as date given

Signature of Vaccine Administrator: X_____

Provider Name: **Natick Board of Health** MDPH Provider PIN#: **11202**

Provider Address: **13 East Central St, Natick MA 01760**

2015-2016 Insurance Information Form

***Place Photo Copy of All Insurance Cards Here:**

For children 18 years of age and younger:

Is Vaccine for Children (VFC) Program eligible:

___Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)

___ Does not have health insurance

___ Is American Indian (Native American) or Alaska Native

Is not VFC-eligible:

___ Has health insurance and is not American Indian (Native American) or Alaska Native

Provider Name: **Natick Board of Health** MDPH Provider PIN#: **11202**

Provider Address: **13 East Central St, Natick MA 01760**